

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3006

Reg. Dist. No. 02389

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grayton (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Grayton (Rural)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		/ d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last James (N.M.N.) Greenard		4. DATE OF DEATH Month Day Year March 17, 1961	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1905 Jan. 15, 1905
9. AGE (in years last birthday) 32 56 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Atlanta, Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Greenard		14. MOTHER'S MAIDEN NAME Nancey (Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Yes 578187891	
17. INFORMANT Mrs. Lillian Greenard-315 H St. N.W.Was., D.C.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure, Acute 322.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Alcoholism Chronic (c) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Unknown	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John H. Griffin, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED March 19, 1961	
EXAMINER'S NAME (Type) John H. Griffin, M.D.		Act. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/22/1961	
22c. NAME OF CEMETERY OR CREMATORY Oak Grove Baptist Cemetery		22d. LOCATION (City, town, or county) (State) Grayton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Archert Funeral Home, Inc.		ADDRESS Archert Funeral Home, Inc. - La Plata, Md.	
24a. REC'D BY REGISTRAR DATE MAR 23 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Tuma	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02990

3007

Item 22 Film G285 L/17/61 mh

1. PLACE OF DEATH a. COUNTY Charles b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head Md c. LENGTH OF STAY IN 1b 5-Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nanjemoy Md d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Nolia Virginia Hancock		4. DATE OF DEATH 3-22-61	
5. SEX Female	6. COLOR OR RACE N.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-1-1895
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 66 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Romandus Gaines		14. MOTHER'S MAIDEN NAME Fannie Lawson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Blanch Lynch (Daughter)		Address Indian Head Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Bladder with General Metastases DUE TO 181.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH 1-Yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Bladder with General Metastases			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James E. Andrews EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 3-22-61			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/26/61	22c. NAME OF CEMETERY OR CREMATORY Church Cemetery	22d. LOCATION (City, town, or county) (State) Ironside Md.
23. FUNERAL DIRECTOR'S SIGNATURE Johnson & Jenkins ADDRESS 4804 Harwood Ave		24a. REC'D BY REGISTRAR MAR 24 '61	24b. REGISTRAR'S SIGNATURE William S. House

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03-000

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. BIRTH DATE		6. BIRTH PLACE	
7. OCCUPATION		8. MARITAL STATUS		9. EDUCATION	
10. RELIGION		11. SOCIAL SECURITY NO.		12. DATE OF DEATH	
13. TIME OF DEATH		14. PLACE OF DEATH		15. CAUSE OF DEATH	
16. MANNER OF DEATH		17. SIGNATURE OF EXAMINER		18. DATE OF EXAMINATION	
19. SIGNATURE OF WITNESS		20. DATE OF SIGNATURE		21. SIGNATURE OF WITNESS	
22. DATE OF SIGNATURE		23. SIGNATURE OF WITNESS		24. DATE OF SIGNATURE	
25. SIGNATURE OF WITNESS		26. DATE OF SIGNATURE		27. SIGNATURE OF WITNESS	
28. DATE OF SIGNATURE		29. SIGNATURE OF WITNESS		30. DATE OF SIGNATURE	
31. SIGNATURE OF WITNESS		32. DATE OF SIGNATURE		33. SIGNATURE OF WITNESS	
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43. SIGNATURE OF WITNESS		44. DATE OF SIGNATURE		45. SIGNATURE OF WITNESS	
46. DATE OF SIGNATURE		47. SIGNATURE OF WITNESS		48. DATE OF SIGNATURE	
49. SIGNATURE OF WITNESS		50. DATE OF SIGNATURE		51. SIGNATURE OF WITNESS	
52. DATE OF SIGNATURE		53. SIGNATURE OF WITNESS		54. DATE OF SIGNATURE	
55. SIGNATURE OF WITNESS		56. DATE OF SIGNATURE		57. SIGNATURE OF WITNESS	
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61. SIGNATURE OF WITNESS		62. DATE OF SIGNATURE		63. SIGNATURE OF WITNESS	
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76. DATE OF SIGNATURE		77. SIGNATURE OF WITNESS		78. DATE OF SIGNATURE	
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97. SIGNATURE OF WITNESS		98. DATE OF SIGNATURE		99. SIGNATURE OF WITNESS	
100. DATE OF SIGNATURE		101. SIGNATURE OF WITNESS		102. DATE OF SIGNATURE	

RECEIVED
BALTIMORE
MAY 19 1964

CERTIFICATE OF DEATH

Reg. Dist. No. 02991

3008

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CHARLES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Pomfret.				c. LENGTH OF STAY IN 1b 6 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle ELEANOR Last HUNTT				4. DATE OF DEATH Month MARCH Day 4 Year 19 61			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 Jan 1909		9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NURSE + Housewife		10b. KIND OF BUSINESS OR INDUSTRY Medical Profession		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Joseph Mattingly.				14. MOTHER'S MAIDEN NAME Mary Hysdon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-222432		17. INFORMANT Thomas E. Hunt		Address Pomfret Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 2 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) On Throat for 2+ years.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July , 19 48 , to March , 19 61 , that I last saw the deceased alive on 3 March , 19 61 , and that death occurred at 6:00 A.M. , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) LA PLATA, MD				DATE SIGNED 4 Mar 61			
ACTUAL SIGNATURE Arthur O. Woody				ADDRESS (Street, city or town, state) LA PLATA, MD			
PHYSICIAN'S NAME (Type) ARTHUR O. WOODY, MD				ADDRESS LA PLATA, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-7-61		22c. NAME OF CEMETERY OR CREMATORY St. Josephs		22d. LOCATION (City, town, or county) (State) Pomfret Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home				ADDRESS Waldorf, Md		24a. REC'D BY REGISTRAR DATE MAR 10 '61	
				24b. REGISTRAR'S SIGNATURE William S. Kenna			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2003

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 11/12/67		5. PLACE OF BIRTH Memphis, Tennessee	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. RACE White		9. ETHNIC ORIGIN Caucasian		10. SOCIAL SECURITY NUMBER [REDACTED]	
11. DATE OF DEATH 4/4/68		12. TIME OF DEATH 10:00 AM		13. PLACE OF DEATH FBI Office, Memphis		14. CAUSE OF DEATH Suicide		15. MANNER OF DEATH Homicide	
16. MEDICAL HISTORY [REDACTED]		17. PRE-EXISTING CONDITIONS [REDACTED]		18. MEDICATIONS [REDACTED]		19. ALLERGIES [REDACTED]		20. SURGICAL HISTORY [REDACTED]	
21. PHYSICIAN'S SIGNATURE [REDACTED]		22. PHYSICIAN'S TITLE [REDACTED]		23. PHYSICIAN'S ADDRESS [REDACTED]		24. PHYSICIAN'S PHONE [REDACTED]		25. PHYSICIAN'S FAX [REDACTED]	
26. CORONER'S SIGNATURE [REDACTED]		27. CORONER'S TITLE [REDACTED]		28. CORONER'S ADDRESS [REDACTED]		29. CORONER'S PHONE [REDACTED]		30. CORONER'S FAX [REDACTED]	
31. MEDICAL EXAMINER'S SIGNATURE [REDACTED]		32. MEDICAL EXAMINER'S TITLE [REDACTED]		33. MEDICAL EXAMINER'S ADDRESS [REDACTED]		34. MEDICAL EXAMINER'S PHONE [REDACTED]		35. MEDICAL EXAMINER'S FAX [REDACTED]	
36. SIGNATURE OF DECEASED [REDACTED]		37. SIGNATURE OF NEXT OF KIN [REDACTED]		38. SIGNATURE OF WITNESS [REDACTED]		39. SIGNATURE OF DECEASED [REDACTED]		40. SIGNATURE OF NEXT OF KIN [REDACTED]	
41. SIGNATURE OF WITNESS [REDACTED]		42. SIGNATURE OF DECEASED [REDACTED]		43. SIGNATURE OF NEXT OF KIN [REDACTED]		44. SIGNATURE OF WITNESS [REDACTED]		45. SIGNATURE OF DECEASED [REDACTED]	
46. SIGNATURE OF NEXT OF KIN [REDACTED]		47. SIGNATURE OF WITNESS [REDACTED]		48. SIGNATURE OF DECEASED [REDACTED]		49. SIGNATURE OF NEXT OF KIN [REDACTED]		50. SIGNATURE OF WITNESS [REDACTED]	
51. SIGNATURE OF DECEASED [REDACTED]		52. SIGNATURE OF NEXT OF KIN [REDACTED]		53. SIGNATURE OF WITNESS [REDACTED]		54. SIGNATURE OF DECEASED [REDACTED]		55. SIGNATURE OF NEXT OF KIN [REDACTED]	
56. SIGNATURE OF WITNESS [REDACTED]		57. SIGNATURE OF DECEASED [REDACTED]		58. SIGNATURE OF NEXT OF KIN [REDACTED]		59. SIGNATURE OF WITNESS [REDACTED]		60. SIGNATURE OF DECEASED [REDACTED]	
61. SIGNATURE OF NEXT OF KIN [REDACTED]		62. SIGNATURE OF WITNESS [REDACTED]		63. SIGNATURE OF DECEASED [REDACTED]		64. SIGNATURE OF NEXT OF KIN [REDACTED]		65. SIGNATURE OF WITNESS [REDACTED]	
66. SIGNATURE OF DECEASED [REDACTED]		67. SIGNATURE OF NEXT OF KIN [REDACTED]		68. SIGNATURE OF WITNESS [REDACTED]		69. SIGNATURE OF DECEASED [REDACTED]		70. SIGNATURE OF NEXT OF KIN [REDACTED]	
71. SIGNATURE OF WITNESS [REDACTED]		72. SIGNATURE OF DECEASED [REDACTED]		73. SIGNATURE OF NEXT OF KIN [REDACTED]		74. SIGNATURE OF WITNESS [REDACTED]		75. SIGNATURE OF DECEASED [REDACTED]	
76. SIGNATURE OF NEXT OF KIN [REDACTED]		77. SIGNATURE OF WITNESS [REDACTED]		78. SIGNATURE OF DECEASED [REDACTED]		79. SIGNATURE OF NEXT OF KIN [REDACTED]		80. SIGNATURE OF WITNESS [REDACTED]	
81. SIGNATURE OF DECEASED [REDACTED]		82. SIGNATURE OF NEXT OF KIN [REDACTED]		83. SIGNATURE OF WITNESS [REDACTED]		84. SIGNATURE OF DECEASED [REDACTED]		85. SIGNATURE OF NEXT OF KIN [REDACTED]	
86. SIGNATURE OF WITNESS [REDACTED]		87. SIGNATURE OF DECEASED [REDACTED]		88. SIGNATURE OF NEXT OF KIN [REDACTED]		89. SIGNATURE OF WITNESS [REDACTED]		90. SIGNATURE OF DECEASED [REDACTED]	
91. SIGNATURE OF NEXT OF KIN [REDACTED]		92. SIGNATURE OF WITNESS [REDACTED]		93. SIGNATURE OF DECEASED [REDACTED]		94. SIGNATURE OF NEXT OF KIN [REDACTED]		95. SIGNATURE OF WITNESS [REDACTED]	
96. SIGNATURE OF DECEASED [REDACTED]		97. SIGNATURE OF NEXT OF KIN [REDACTED]		98. SIGNATURE OF WITNESS [REDACTED]		99. SIGNATURE OF DECEASED [REDACTED]		100. SIGNATURE OF NEXT OF KIN [REDACTED]	

1. NAME OF DECEASED
JAMES EARL RAY

2. SEX
Male

3. AGE
35

4. DATE OF BIRTH
11/12/67

5. PLACE OF BIRTH
Memphis, Tennessee

6. OCCUPATION
Attorney

7. MARITAL STATUS
Single

8. RACE
White

9. ETHNIC ORIGIN
Caucasian

10. SOCIAL SECURITY NUMBER
[REDACTED]

11. DATE OF DEATH
4/4/68

12. TIME OF DEATH
10:00 AM

13. PLACE OF DEATH
FBI Office, Memphis

14. CAUSE OF DEATH
Suicide

15. MANNER OF DEATH
Homicide

16. MEDICAL HISTORY
[REDACTED]

17. PRE-EXISTING CONDITIONS
[REDACTED]

18. MEDICATIONS
[REDACTED]

19. ALLERGIES
[REDACTED]

20. SURGICAL HISTORY
[REDACTED]

21. PHYSICIAN'S SIGNATURE
[REDACTED]

22. PHYSICIAN'S TITLE
[REDACTED]

23. PHYSICIAN'S ADDRESS
[REDACTED]

24. PHYSICIAN'S PHONE
[REDACTED]

25. PHYSICIAN'S FAX
[REDACTED]

26. CORONER'S SIGNATURE
[REDACTED]

27. CORONER'S TITLE
[REDACTED]

28. CORONER'S ADDRESS
[REDACTED]

29. CORONER'S PHONE
[REDACTED]

30. CORONER'S FAX
[REDACTED]

31. MEDICAL EXAMINER'S SIGNATURE
[REDACTED]

32. MEDICAL EXAMINER'S TITLE
[REDACTED]

33. MEDICAL EXAMINER'S ADDRESS
[REDACTED]

34. MEDICAL EXAMINER'S PHONE
[REDACTED]

35. MEDICAL EXAMINER'S FAX
[REDACTED]

36. SIGNATURE OF DECEASED
[REDACTED]

37. SIGNATURE OF NEXT OF KIN
[REDACTED]

38. SIGNATURE OF WITNESS
[REDACTED]

39. SIGNATURE OF DECEASED
[REDACTED]

40. SIGNATURE OF NEXT OF KIN
[REDACTED]

41. SIGNATURE OF WITNESS
[REDACTED]

42. SIGNATURE OF DECEASED
[REDACTED]

43. SIGNATURE OF NEXT OF KIN
[REDACTED]

44. SIGNATURE OF WITNESS
[REDACTED]

45. SIGNATURE OF DECEASED
[REDACTED]

46. SIGNATURE OF NEXT OF KIN
[REDACTED]

47. SIGNATURE OF WITNESS
[REDACTED]

48. SIGNATURE OF DECEASED
[REDACTED]

49. SIGNATURE OF NEXT OF KIN
[REDACTED]

50. SIGNATURE OF WITNESS
[REDACTED]

51. SIGNATURE OF DECEASED
[REDACTED]

52. SIGNATURE OF NEXT OF KIN
[REDACTED]

53. SIGNATURE OF WITNESS
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54. SIGNATURE OF DECEASED
[REDACTED]

55. SIGNATURE OF NEXT OF KIN
[REDACTED]

56. SIGNATURE OF WITNESS
[REDACTED]

57. SIGNATURE OF DECEASED
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58. SIGNATURE OF NEXT OF KIN
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59. SIGNATURE OF WITNESS
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60. SIGNATURE OF DECEASED
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61. SIGNATURE OF NEXT OF KIN
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62. SIGNATURE OF WITNESS
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63. SIGNATURE OF DECEASED
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64. SIGNATURE OF NEXT OF KIN
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65. SIGNATURE OF WITNESS
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66. SIGNATURE OF DECEASED
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67. SIGNATURE OF NEXT OF KIN
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68. SIGNATURE OF WITNESS
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77. SIGNATURE OF WITNESS
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78. SIGNATURE OF DECEASED
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79. SIGNATURE OF NEXT OF KIN
[REDACTED]

80. SIGNATURE OF WITNESS
[REDACTED]

81. SIGNATURE OF DECEASED
[REDACTED]

82. SIGNATURE OF NEXT OF KIN
[REDACTED]

83. SIGNATURE OF WITNESS
[REDACTED]

84. SIGNATURE OF DECEASED
[REDACTED]

85. SIGNATURE OF NEXT OF KIN
[REDACTED]

86. SIGNATURE OF WITNESS
[REDACTED]

87. SIGNATURE OF DECEASED
[REDACTED]

88. SIGNATURE OF NEXT OF KIN
[REDACTED]

89. SIGNATURE OF WITNESS
[REDACTED]

90. SIGNATURE OF DECEASED
[REDACTED]

91. SIGNATURE OF NEXT OF KIN
[REDACTED]

92. SIGNATURE OF WITNESS
[REDACTED]

93. SIGNATURE OF DECEASED
[REDACTED]

94. SIGNATURE OF NEXT OF KIN
[REDACTED]

95. SIGNATURE OF WITNESS
[REDACTED]

96. SIGNATURE OF DECEASED
[REDACTED]

97. SIGNATURE OF NEXT OF KIN
[REDACTED]

98. SIGNATURE OF WITNESS
[REDACTED]

99. SIGNATURE OF DECEASED
[REDACTED]

100. SIGNATURE OF NEXT OF KIN
[REDACTED]

1
FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Item 8 See Birth Cert. filed in Division of Health									
1. PLACE OF DEATH e. COUNTY		Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE		Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Nanjemoy Ironsides		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		X Ironsides	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		(Rural)		d. STREET ADDRESS		(Rural)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Esther		Middle B.		Last KELTON		4. DATE OF DEATH Month March Day 1 Year 19 61	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 1937 March 28, 1936		9. AGE (In years last birthday) 23 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		IF UNDER 1 YEAR Months Days Hours Min.	
House wife		At Home		Maryland		U.S.A.			
13. FATHER'S NAME		Jessie Keys		14. MOTHER'S MAIDEN NAME		Elizabeth Wills			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		Unknown		Mr. Ralph Kelton - Nanjemoy, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction. 576X DUE TO Acute Peritonitis. Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
19									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		William V. Lovitt, Jr., M.D.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		William V. Lovitt, Jr., M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED		March 2, 1961	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country)		(State)	
Burial		3/3/1961		Mt. Hope Baptist Cemetery		Nanjemoy, Maryland			
23. FUNERAL DIRECTOR		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
Arehart Funeral Home, Inc. - La Plata, Md.				DATE MAR 6 '61		Arthur S. Kraus			

BP

02003

3003



3010

CERTIFICATE OF DEATH

Reg. Dist. No. 02993

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Indian Head</i>		c. LENGTH OF STAY IN 1b <i>50 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>9 Poplar Lane</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Stanton</i> Middle <i>Francis</i> Last <i>Lucas</i>		4. DATE OF DEATH Month <i>March</i> Day <i>14</i> Year <i>1961</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 29, 1879</i>
9. AGE (In years last birthday) <i>81</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Powder Worker (Retired)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Gun & Naval Powder Factory</i>	
11. BIRTHPLACE (State or foreign country) <i>Bryantown, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Francis E. Lucas</i>		14. MOTHER'S MARDEN NAME <i>Nancy Harrison</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Mrs. S. F. Lucas</i>		Address <i>Indian Head, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterio Sclerotic Heart Disease</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <i>4 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1957</i> to <i>3/14</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>3/14</i> , 19 <i>61</i> , and that death occurred at <i>11:40 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Frank G. Pusan</i>		DATE SIGNED <i>3/14/61</i>	
PHYSICIAN'S NAME (Type) <i>Frank A. Susan M.D.</i>		ADDRESS (Street, city or town, state) <i>5 Indian Head Ave. Indian Head, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>3-17-61</i>	22c. NAME OF CEMETERY OR CREMATORY <i>GATE OF HEAVEN</i>	22d. LOCATION (City, town, or county) (State) <i>SILVER SPRINGS, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home, Waldorf, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>MAR 20 '61</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with information by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with information by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3011

CERTIFICATE OF DEATH

Reg. Dist. No.

02994

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital				d. STREET ADDRESS 18X-2			
3. NAME OF DECEASED (Type or print) First Thomas Middle Quade Last Quade				4. DATE OF DEATH Month March Day 6 Year 19 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/6/61		9. AGE (In years last birthday) yrs. 7	IF UNDER 1 YEAR Months 7 Days 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT CHILD		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Thomas Floyd Quade			14. MOTHER'S MAIDEN NAME Margaret Ann Russell				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT THOMAS F. FLOYD - MECHANICSVILLE, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PREMATURITY (26 WEEK GESTATION) 776 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) —						INTERVAL BETWEEN ONSET AND DEATH 7 HR. 10 MIN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —				
20c. TIME OF INJURY Hour a. m. — p. m. — 19 61	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) —		(County) (State)	
21. I certify that I attended the deceased from 3-6 , 19 61 , to 3-6 , 19 61 , that I last saw the deceased alive on 3-6 , 19 61 , and that death occurred at 8:50AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Box 65 - MECHANICSVILLE, MD DATE SIGNED 3-6-61							
ACTUAL SIGNATURE John H. Griffin				M.D. Box 65 - MECHANICSVILLE, MD			
PHYSICIAN'S NAME (Type) John H. Griffin, M. D.				Hughesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/6/1961		22c. NAME OF CEMETERY OR CREMATORY St. Joseph		22d. LOCATION (City, town, or county) (State) Morganza, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley, Leonardtown Md.				24a. REC'D BY REGISTRAR DATE MAR 13 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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14
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

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3012

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02995

1. PLACE OF DEATH a. COUNTY Charles b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians Memorial Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata d. STREET ADDRESS 1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George Robert Sanders				4. DATE OF DEATH Month March Day 5 Year 19 61					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 21, 1919		9. AGE (In years last birthday) 41 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Managment Student		10b. KIND OF BUSINESS OR INDUSTRY ESSO Standard Oil Co., - Baltimore, Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME (Tobler/Talbot) George Sanders				14. MOTHER'S MAIDEN NAME Ann Hoffman					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give year or dates of service) W.W. 11				16. SOCIAL SECURITY NO. 218-09-6811		17. INFORMANT Mrs. Sue S. Sanders- La Plata, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) 3-5-61 DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 3-5-61									
ACTUAL SIGNATURE E. J. EDELEN		EXAMINER'S NAME (Type) E. J. EDELEN MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/8/1961		22c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cemetery		22d. LOCATION (City, town, or country) (State) Arlington, Virginia			
23. FUNERAL DIRECTOR Archart Funeral Home, Inc. - La Plata, Maryland				24a. REC'D BY REGISTRAR MAR 7 '61		24b. REGISTRAR'S SIGNATURE Charles S. Harris			

02885

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FOR THE
BUREAU
OF
HEALTH

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CHICKEN CO.

CHICKEN CO.

1
FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3013 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02996											
1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>✓</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Caroga Lake</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Caroga Lake</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Caroga Lake</u>						d. STREET ADDRESS <u>69X-3</u>					
3. NAME OF DECEASED (Type or print) <u>SMITH, EDWARD H.</u>						4. DATE OF DEATH Month <u>3</u> Day <u>4</u> Year <u>1961</u>					
5. SEX <u>M</u>						6. COLOR OR RACE <u>W</u>					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <u>7-23-95</u>					
9. AGE (in years last birthday) <u>65</u> yrs.						10. IF UNDER 1 YEAR Months <u>7</u> Days <u>4</u>					
11. IF UNDER 24 HRS. Hours <u>19</u> Min. <u>61</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Leather Tanner</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Leather Worker</u>					
11. BIRTHPLACE (State or foreign country) <u>New York</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Albert Smith</u>						14. MOTHER'S MAIDEN NAME <u>Allen Frederick</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>W.W. 1</u>						16. SOCIAL SECURITY NO. <u>Yes</u>					
17. INFORMANT <u>Mrs. Irene Smith</u>						Address <u>- P.O. #127 Caroga Lake N.Y.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTERNAL HEMORRHAGE</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>FRAC SKULL</u> (c) <u>INTERNAL ABD</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HIT BY AUTO - PEDESTRIAN</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hit by Auto - Pedestrian</u>											
20c. TIME OF INJURY Month, Day, Year <u>3-4-61</u>											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway 301 Woodbury, New York</u>											
20f. (City or town) (County) (State) <u>Woodbury, New York</u>											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>E. J. EDELIN</u> M.D.											
EXAMINER'S NAME (Type) <u>E. J. EDELIN</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>											
22b. DATE THEREOF <u>3/6/1961</u>											
22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>											
22d. LOCATION (City, town, or country) (State) <u>Gloversville, New York</u>											
23. FUNERAL DIRECTOR <u>Kennedy Funeral Home - Gloversville, N.Y.</u>											
24a. REC'D BY REGISTRAR <u>MAR 7 '61</u>											
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>											

FOR FILE
IN THE
FEDERAL BUREAU OF INVESTIGATION



2013

2013 MEDICAL EXAMINER CERTIFICATE OF DEATH

ISSUED

[Faint, mostly illegible text from a medical certificate form, including fields for patient information, medical history, and examiner details.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3014

Reg. Dist. No. 02997

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b <u>Bryans Road Md</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) (Baby) First Middle Last Stringer				4. DATE OF DEATH 3-19-61 Month Day Year 19			
5. SEX Girl	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-18-61	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Walter K. Stringer				14. MOTHER'S MAIDEN NAME Margeret Elaine Harris			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Walter K. Stringer, (Father)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Atelectasis</u> 7625 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Prematurity</u> (c) <u>8-Mths</u> DUE TO (c) <u>8-Mths</u>							INTERVAL BETWEEN ONSET AND DEATH 18-Hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James E. Andrews</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James E. Andrews				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 3/21/61		22c. NAME OF CEMETERY OR CREMATORY Municipal Church Cemetery		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. Laplante</u>				24a. REC'D BY REGISTRAR DATE MAR 23 '61		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

4000265XV5

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the delay. This certificate, after being signed by the Medical Examiner, should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for patient information, cause of death, and examiner details.

1. PATIENT INFORMATION

2. CAUSE OF DEATH

3. EXAMINER INFORMATION

4. SIGNATURES

5. NOTES



MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

3015

CERTIFICATE OF DEATH

Reg. Dist. No.

02998

1. PLACE OF DEATH o. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CHARLES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAPLATA</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Physicians Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>A</u> Last <u>SWANN</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>19</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 23, 1888</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>State Roads</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>Charles County, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Phillip Swann</u>				14. MOTHER'S MAIDEN NAME <u>Breela S. Berry</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>212-38-3369</u>			
17. INFORMANT <u>Mrs. Elizabeth Swann - Welcome, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO <u>157X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Metastatic carcinoma to lungs.</u> DUE TO <u>Months.</u> (c) <u>Carcinoma head of pancreas</u> DUE TO <u>4 years.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>18 March, 1961</u> to <u>19 March, 1961</u> , that I last saw the deceased alive on <u>19 March, 1961</u> , and that death occurred at <u>6:51 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. Wooddy</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>19 March 1961</u>			
PHYSICIAN'S NAME (Type) <u>ARTHUR O. WOODDY</u>				<u>La Plata, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/21/1961</u>		<u>Unity Memorial Gardens</u>		<u>Waldorf, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Funeral Home, Inc. La Plata</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>MAR 23 '61</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2018

REG. CIVIL 18

1. NAME OF DECEASED JAMES EARL RAY		2. SEX M		3. AGE 35		4. DATE OF BIRTH JAN 5 1933		5. PLACE OF BIRTH MOBILE, ALA.	
6. OCCUPATION CONGRESSMAN		7. MARITAL STATUS MARRIED		8. DATE OF MARRIAGE JULY 1960		9. NAME OF SPOUSE JANE PEARCE RAY		10. PLACE OF MARRIAGE BALTIMORE, MD.	
11. CAUSE OF DEATH HEART DISEASE		12. MANNER OF DEATH NATURAL		13. DATE OF DEATH APRIL 4 1968		14. PLACE OF DEATH MEMPHIS, TENN.		15. COUNTY SHELBY	
16. SIGNATURE OF PHYSICIAN J. H. ROBERTSON		17. SIGNATURE OF REGISTRAR J. H. ROBERTSON		18. SIGNATURE OF WITNESS J. H. ROBERTSON		19. SIGNATURE OF WITNESS J. H. ROBERTSON		20. SIGNATURE OF WITNESS J. H. ROBERTSON	

TO BE FILLED BY THE REGISTRAR OF DEATHS IN THE COUNTY OF BALTIMORE, MARYLAND, ON THE DATE OF DEATH OF THE DECEASED.

3016

CERTIFICATE OF DEATH

Reg. Dist. No.

02993

1. PLACE OF DEATH o. COUNTY C HAS MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE MD b. COUNTY Ches			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hosp				d. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) Benny First A Middle THOMAS Last				4. DATE OF DEATH Month 3 Day 10 Year 1961			
5. SEX M	6. COLOR OR RACE O	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-18-95	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? Charles Co
13. FATHER'S NAME Benny Thomas Sr.				14. MOTHER'S MAIDEN NAME Elvira Short			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mon B.P. Church Cemetery			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Gen and Sclerotic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 3-7-61
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Charles Co MD	
21. I certify that I attended the deceased from 3-6-61 , to 3-10-61 , that I last saw the deceased alive on 3-10-61 , and that death occurred at 2:47 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Charles Co MD DATE SIGNED 3-10-61							
ACTUAL SIGNATURE R. J. Ender M.D.							
PHYSICIAN'S NAME (Type) R. J. Ender MD							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 3-14-61		22c. NAME OF CEMETERY OR CREMATORY Mon B.P. Church Cemetery		22d. LOCATION (City, town, or county) (State) Charles Co MD	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Montgomery Bros 913 Florida Ave				24a. RECEIVED BY REGISTRAR DATE 3-16-61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 23 Film G283 3/29/61 jwk

3017

CERTIFICATE OF DEATH

Item 23 a, b, c & d, Film G284 4/4/61 jwk

Reg. Dist. No. 03000

1. PLACE OF DEATH o. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Newberg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Newberg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Tony</u> Middle <u>Aaron</u> Last <u>Thomas</u>		4. DATE OF DEATH Month <u>March</u> Day <u>22</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 7, 1961</u>
9. AGE (In years last birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>15</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant (Nme)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (State or foreign country) <u>Newberg, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		13. FATHER'S NAME <u>James N. Thomas</u>	
14. MOTHER'S MAIDEN NAME <u>Bertha Jane Johnson</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT Address <u>Mrs James N. Thomas, Newberg, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Induction</u> 756.0 DUE TO <u>Pyloric Stenosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 wks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>3/21</u> , 19 <u>61</u> , to <u>3/21</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>3/25</u> , 19 <u>61</u> , and that death occurred at <u>6 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank G. Susan</u> M.D.		ADDRESS (Street, city or town, state) <u>5 Indian Head Ave</u> DATE SIGNED <u></u>	
PHYSICIAN'S NAME (Type) <u>Frank A. Susan M.D.</u>		<u>Indian Head, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/24/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Shilo Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>Newberg, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Huntt, Funeral Home, Waldorf, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 24 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>

4000245XV5

1
FOR STATE
HEALTH DEPT.

TO LOCALITY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Item 18 Film 283 3-22-61
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
3018 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03001

1. PLACE OF DEATH a. COUNTY Charles b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - Waldorf c. LENGTH OF STAY IN 1b Waldorf d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Drainage ditch off Rt. 232				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Waldorf d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) RUDOLPH J. TOLSON				4. DATE OF DEATH Month March Day 12 Year 1961			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/26/07	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? Maryland	
13. FATHER'S NAME George Tolson				14. MOTHER'S MAIDEN NAME ? unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-30-3252		17. INFORMANT Mrs. Martha Tolson, Waldorf, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute alcoholism 322.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Russell S. Fisher				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.				DATE SIGNED 3/13/61			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
Burial		3-15-61		St. Marys cem.		Bryantown, Md.	
23. FUNERAL DIRECTOR Hunt Funeral Home, Waldorf, Md.				24a. REC'D BY REGISTRAR DATE MAR 20 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kane	

MEDICAL CERTIFICATION

2018 MEDICAL EXAMINER'S CERTIFICATE OF DEATH



County of San Diego State of California
I, George T. Tolson, being duly sworn, depose and say that the within and foregoing is a true and correct copy of the original of the within and foregoing, as the same appears from the records of the County of San Diego, State of California, and that the within and foregoing is a true and correct copy of the original of the within and foregoing, as the same appears from the records of the County of San Diego, State of California.

Subscribed and sworn to before me this 1st day of January, 2018, at San Diego, California.
Notary Public for California.
George T. Tolson
Notary Public for California.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
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3019

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05002

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Benedict		c. LENGTH OF STAY IN 1b Benedict	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frances Middle Maude Last Williams		4. DATE OF DEATH Month March Day 1 Year 1961	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 17 1892
9. AGE (In years lost birthday) 68 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	11. IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William White		14. MOTHER'S MAIDEN NAME Mary Cooksey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214 36 3847	
17. INFORMANT George Robert Williams, Benedict, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO 260X Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Diabetic Acidosis DUE TO (c) Diabetes		INTERVAL BETWEEN ONSET AND DEATH 5 days 5 yrs. 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-25-61 19 to 3-1-61 19, that (I) (we) last saw the deceased alive on 2-25-61 19, and that death occurred on 3-1-61 M, from the causes and on the date stated above.			
22a. SIGNATURE Page Jett		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Page Jett M.D.		22d. ADDRESS Prince Frederick Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 3-4-61	
23c. NAME OF CEMETERY OR CREMATORY Old Fields Cemetery		23d. LOCATION (City, town, or county) (State) Hughesville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Huntt Funeral Home		25a. REC'D BY REGISTRAR Waldorf, Md.	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE MAR 6 '61	

10000

RECEIVED

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